



PATIENT TRANSFER REPORTING FORM

(Pursuant to Business and Professions Code Section 2240)

1. Name of Patient's Outpatient Setting Physician: Last _____ First _____ Middle _____ Physician's License Number: _____	
2. Name of Physician with Hospital Privileges (if the same as above, leave blank): Last _____ First _____ Middle _____ Physician's License Number: _____	
<div style="display: flex; justify-content: space-between;"> <div> 3. Patient Name: Last _____ First _____ Middle _____ Address: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Number Street City State ZIP Code </div> </div> <div> Medical Record Number: _____ Date of Birth: _____ </div> </div>	
3a. Patient Identifier (Social Security Number, Patient ID Number, etc.): _____	
4. Name and Address of Hospital or Emergency Center where Patient was Transferred: _____	
<p>State law (Section 2240(b) of the California Business and Professions Code) requires that a completed copy of this entire form be placed in a patient's file. After completing the form, make 2 photo copies of the full form. Send 1 copy to the facility identified in #4 above for insertion in the patient's record. With the second copy, cut on line and mail the bottom portion within 15 days of the transfer to:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Office of Statewide Health Planning and Development Patient Discharge Data Section Attn: Physician Reporting-Transfers 818 K Street, Suite 100 Sacramento, CA 95814</p> </div> <div style="width: 45%; text-align: right;"> <p><i>*As of January 1, 2002 per B&P Code 2240, this form should be mailed to the Office of Statewide Health Planning and Development.</i></p> </div> </div> <p>✂ _____</p>	
5. Specific Procedure(s) Performed: _____	
5a. _____ Sex of Patient _____ Age of Patient _____ County of Surgical Setting	
6. Transfer for postoperative care was planned and arranged with hospital prior to surgery: ____ yes ____ no	
6a. Events triggering/necessitating transfer (including pre-arranged post operative care): ____ respiratory distress ____ drug reaction ____ cardiovascular distress ____ excessive bleeding ____ other (please specify) _____	
Details of event (Please attach explanation if more space is needed and include in patient's chart and mailing to the Office of Statewide Health Planning and Development). _____	
7. Duration of Hospital Stay: ____ Day(s) ____ Week(s) ____ Month(s)	8. Final Disposition: ____ Patient Died ____ Patient Sent Home ____ Other (please specify)
9. Physician Practice Specialty and ABMS Certification: _____	

Date of Report: _____